

Reservoir High School Music

11550 Scaggsville Road • Fulton, Maryland 20759

Phone: 410-888-8864 • Fax: 410-888-8849



RESERVOIR OVERNIGHT MEDICAL REPORT

Name _____ Grade _____ Date _____

Date of Birth _____ Male _____ Female _____

Current Address _____

Parent/Guardian _____ Phone _____

Relative or Other
Responsible Party _____ Phone _____

Health History: (please give dates where known)

Operation (within last year) _____

Emotion Problems (i.e. hyperventilator, etc.) _____

Serious Medical Problems _____

Rheumatic Fever _____

Diabetes _____

Epilepsy _____

Allergy _____

Tetanus (last injection) _____

Any special health problems in past? _____

(continue on back)

Allergy to Drugs (specify, i.e. Penicillin) _____

Any Medications Patient is on: (include anti-convulsive, antihistamine, insulin and Tranquilizers) _____

Is child under medical treatment at present time? _____

Reason: _____

Family Physician _____

Telephone number of Physician (include area code) _____

This is permission for treatment of above person by Physician and at hospital for any medical or surgical emergency.

Parent/Guardian Signature

Insurance Company _____

Agreement No. _____

Group Number _____

Please attach a copy of your medical insurance card. Be sure to include both the front and back sides of your card.